



BAILLIARD HENRY PEDIATRIC CARDIOLOGY

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PATIENT ACKNOWLEDGMENT AND CONSENT OF PRIVACY PRACTICES

I have been given a copy of Bailliard Henry Pediatric Cardiology, PLLC’s Notice of Privacy Practices, version effective 09/23/2013. I consent to the uses and disclosures of my/my child’s health information as outlined in the Notice.

I authorize **Bailliard Pediatric Cardiology, PLLC** to leave voice messages on my **home/cell phone** (*circle one*) with regard to my child(ren)/myself (*circle one*) that assist in carrying out TPO (treatment, payment, healthcare operations), until this notice is revoked in writing. ____ (initials)

I authorize **Bailliard Pediatric Cardiology, PLLC** to send to my email account, email messages with regard to my child(ren)/myself (*circle one*) that assist in carrying out TPO, until this notice is revoked in writing. ____ (initials)

Patient Name

Date

Signature of Representative/Patient

Relationship of Representative to Patient

FOR BAILLIARD HENRY PEDIATRIC CARDIOLOGY USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient’s representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

